Special Agents Mutual Benefit Association
ESTABLISHED 1948

11301 Old Georgetown Road
Rockville, MD 20852-2800
(301) 984-1440 • (800) 638-6589
Fax (301) 816-0191

Employee Benevolent Fund

The Special Agents Mutual Benefit Association (SAMBA) offers the Employee Benevolent Fund to active employees of Customs and Border Protection (CBP), Immigration and Customs Enforcement (ICE) and Citizenship and Immigration Service (CIS).

Important Information:

The Employee Benevolent Fund ("the Fund") provides a **$17,500** death benefit to the designated beneficiary(ies) of a deceased member. The Fund is underwritten by The Prudential Insurance Company of America.

- The cost of the Fund is **$1** biweekly and will be paid through payroll allotment.
- Benefit payments under the Fund are generally made without a death certificate initially and within 24 hours after SAMBA has been notified by the CBP, ICE, CIS agency representative of a member's death.
- Enrollment is open to all permanent full-time or part-time active employees of CBP, ICE and CIS – without proof of insurability – who enroll during an established Open Enrollment Period. Newly hired employees may enroll within 30 calendar days following their entry on duty date with their agency.

Coverage is effective beginning of the first pay period in which the Employee Benevolent Fund premium is withheld. It is the member's responsibility to arrange for payment of biweekly premiums directly to SAMBA during any periods of Leave Without Pay (LWOP) for any reason. Membership in the Fund will terminate when a member ceases to be an active employee of CBP, ICE or CIS, after 365 consecutive calendar days of LWOP status, or for non-payment of premium. All administrative and operational matters pertaining to the Fund are pursuant to the SAMBA Employee Benevolent Fund Policy and signed agreement with CBP, ICE and CIS.

To Enroll:

1. Complete the Employee Benevolent Fund Application and return to SAMBA . Please fill out the application so that it fully and accurately describes your request. List the full name, address, relationship to the insured, and birth date of the beneficiary(ies). Note: The beneficiary(ies) designated by the insured must be a natural person(s). **Minors and trusts cannot be designated as primary beneficiary(ies).** If you reside in one of the Community Property States (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin) and want to designate a beneficiary other than your spouse, your spouse's signature is required. SAMBA, the Administrator of the Fund, will acknowledge receipt of the Application and return a copy for your files.
2. Complete and return to SAMBA the Payroll Allotment Form 299 to authorize the biweekly premium to be withheld from your pay.

To change your beneficiary(ies) please execute another Employee Benevolent Fund Application designating the new beneficiary(ies). To be valid, the application updating your beneficiary(ies) must be received and recorded in the SAMBA Office prior to the death of the member.

Mail to:
SAMBA
11301 Old Georgetown Road
Rockville, MD 20852-2800
(301) 984-1440 or 1-800-638-6589
Visit our website at: www.SambaPlans.com

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EMPLOYEE BENEVOLENT FUND APPLICATION

Please check the appropriate box:

☐ Open Enrollment Period
☐ Enrollment within 30 days of EOD
☐ Change of Beneficiary
☐ Name and/or address change

Member Information (Please Print or Type):

Full Name of Employee: _____ SSN: _____ – _____ – _____

Mailing Address: _____ Sex: ☐ Male ☐ Female

_____ Date of Birth: _____ – _____ – _____

Agency: **CBP / ICE / CIS** EOD Date: _____ – _____ – _____ Email: _____

Work Phone Number (_____) _____ – _____ Home Phone Number (_____) _____ – _____

☐ **PRIMARY BENEFICIARY(IES):** (In equal shares or as designated below.) Primary beneficiary(ies) must be a natural person(s). Minors and trusts cannot be designated as primary beneficiary(ies).

Full Name and Address (Example: Mary A. Doe, not Mrs. John J. Doe)	% of Proceeds	Relationship to Insured	Date of Birth

As shall then be living, and if no such beneficiary is then living
☐ **CONTINGENT BENEFICIARY(IES):** (In equal shares or as designated below.)

Full Name and Address (Example: Mary A. Doe, not Mrs. John J. Doe)	% of Proceeds	Relationship to Insured	Date of Birth

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Signature of Employee Date

Signature of Spouse (Required only in Community Property States; AZ, CA, ID, LA, NV NM, TX, WA, WI) Date

Received & Acknowledged by Authorized SAMBA Representative Date

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REQUEST BY EMPLOYEE FOR ALLOTMENT OF PAY; MAIL WITH YOUR APPLICATION TO SAMBA, 11301 OLD GEORGETOWN RD, ROCKVILLE, MD 20852-2800

PRIVACY ACT STATEMENT

The information collected on this form is authorized by 5 U.S.C. 5527, which authorizes disbursing officers to permit employees to make allotments of their pay under regulations issued by the Office of Personnel Management. The information will be used primarily to identify you in your agency's payroll system (by employee number) and to process the payment of the allotment. Other possible disclosures of the information would be to a court or a federal, state or local taxing authority.

Executive Order 9397 permits use of the Social Security Number (SSN) as the means of identifying individuals in personnel record systems. Furnishing your SSN or any other information on this form is voluntary. However, failure to provide your employee identification number (or SSN when it is used by your agency as the employee identification number) or any of the other requested data may result in your agency not being able to process your request.

PART 1 - COMPLETE SHADED AREAS ONLY.

1. Employee's Name (As Stated on Pay Check)	**2.** Employee's Social Security Number
3. Employee's Home Address (Number, Street, City, State & Zip Code)	**4.** Payroll Office Location (City, State)
5. Employee Agency (Include Bureau, Division, Branch, or Other Designation)	**6.** Employee's Telephone Number
7. Action Requested ☐ New Allotment . . . . . .$_____ ☐ Increase Allotment to Total of . . . . . .$_____ ☐ Decrease Allotment to Total of . . . . . .$_____ ☐ Cancel Allotment (for all Plans) ☐ Only Cancel for Plans Listed Below _____	**8.** Employee's Account Number in the Financial Organization 0970192980 **9.** Recipient of Allotment *(Name & Mailing Address)* M & T Bank POST OFFICE BOX 64629 BALTIMORE, MD 21264-4629 **TRN 052000113**
10 ☐ I wish to continue as an Associate Member	

11 **Authorization and Certification by Employee**
You are hereby authorized, under 5 CFR 550.311 to take the action requested above with respect to deductions from salary or wages due me in the amount specified in Item 7, which are for remittance to the individual/organization, as designated in Item 8. I understand that this allotment will continue until canceled by me in writing.
I agree that the agency shall be held harmless for this allotment and that any disputes regarding this allotment shall be a matter between me and the individual/organization designated in Item 8 to receive the remittance.

12 Signature Date Signed

PART 2 - To be completed by Organization/Individual Receiving the Allotment

(Complete this part for a new allotment. It may be completed for changes to, or cancellations of, an existing allotment determined by agency policy.)

13 **Acknowledgment and Certification by Recipient of Allotment**
We, the above-designated financial organization, hereby agree to act as agent of the above-named Government employee.

Maureen Lewandowski — Authorized Signature

VICE PRESIDENT — **Title**

FOR SPECIAL ATTENTION OF EMPLOYEE (AND FOR INFORMATION OF THE FINANCIAL ORGANIZATION)

Agency payroll offices and disbursing offices operate within rigid time schedules to assure timely delivery of checks for net pay on the established payday - and there will be no change in this emphasis. As requested above, the amount allotted will be deducted from your salaries or wages and will be remitted by the disbursing office, as soon as practicable, to the designated financial organization. *It should be understood that such remittance may be received in the financial organization later than the regular payday - possible 3 or 4 business days later.*